Child Safety
Commission of Inquiry

Nannie's story

Disclaimer: *This is the story of a person who shared their personal experience with the Commission of Inquiry through a submission or interview. The names in this story are pseudonyms and identifying details have been removed. The person who shared this experience may not have been a witness and their account is not evidence. They did not take an oath or affirmation before providing the story.*

Nothing in this story constitutes a finding of fact by the Commission of Inquiry. Instead, these stories have been published to show how people are experiencing the current child safety system in Queensland. Any views expressed are those of the person who shared their experience, not of the Commission of Inquiry.

Content warning: *Some material may be distressing. These statements may include references to violence, abuse, neglect, exploitation, suicide, or self-harming behaviours, and may contain strong or confronting language. Some narratives may be about First Nations people who have passed away. Readers are encouraged to engage with this material in a way that supports their wellbeing.*

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1. Introduction

I am a practitioner with over 15 years' experience working in child protection in the [redacted]. I have been living and working in Queensland, Australia, for approximately [redacted].

Through professional experience and discussions with practitioners across multiple sectors, I have identified consistent concerns regarding delays in response to children at risk of significant harm, limited multi-agency coordination, and gaps in statutory intervention pathways.

This submission is informed by comparative practice experience and recurring themes raised by professionals currently working within the Queensland system.

2. Key Concerns

There appear to be four interconnected systemic issues:

1. **Delayed responses to children at risk of significant harm**
2. **Limited or inconsistent multi-agency coordination**
3. **A gap in structured statutory intervention prior to crisis point**
4. **Absence of formalised child protection planning with multi-agency accountability**

Together, these issues contribute to children remaining in unsafe environments and not receiving timely or effective support.

3. Delays in Response to Risk of Significant Harm

There appears to be a pattern of delays in responding to notifications involving significant harm, with some cases reportedly remaining unallocated or unassessed for extended periods.

This results in:

- Children remaining in environments where harm is known or suspected
- Escalation of abuse, neglect, or risk-taking behaviours
- Missed opportunities for early intervention

4. Gap in Statutory Intervention Pathways

A key difference observed between the Queensland system and the United Kingdom is the **lack of a clearly defined statutory intervention stage prior to removal of children**.

In practice, there appears to be a progression of:

- Initial assessment
- Voluntary engagement with families

However, where voluntary engagement is declined or ineffective, there is limited structured escalation until risk reaches a level requiring removal.

This creates a gap where:

- Risks are known but not formally managed
- Families are not held to clear, enforceable expectations
- Professionals lack a consistent framework for intervention

In contrast, systems such as those in the UK include a **statutory child protection stage**, where:

- Risk of significant harm triggers formal intervention
- Agencies are required to work together under a structured plan
- Progress is monitored and reviewed

This allows for earlier, more consistent intervention without immediate removal.

5. Absence of Formal Child Protection Plans

Linked to the above is the absence of a consistent, formalised **child protection planning process** with multi-agency accountability.

In effective safeguarding systems, child protection plans:

- Clearly outline identified risks
- Set expectations for parents and caregivers
- Define required actions for each agency
- Are reviewed regularly in multi-agency settings

The absence of this structure may result in:

- Drift in case management
- Lack of clarity around responsibility
- Limited accountability for change
- Increased likelihood of escalation to crisis

6. Adolescents, "Self-Placing", and Missing Children

There are also concerns regarding the response to adolescents engaging in high-risk behaviours.

In particular:

- Children (including those as young as 14) may be considered able to "self-place"
- Missing episodes do not always trigger consistent or immediate intervention
- Police and child safety responses may be limited

This can result in:

- Young people remaining in unsafe environments
- Exposure to exploitation, violence, or criminal activity
- Lack of coordinated response to escalating risk

Parents may experience:

- Feeling unsupported and powerless
- Inability to safeguard their child
- Limited access to meaningful intervention

7. Lack of Structured Multi-Agency Coordination

There appears to be limited evidence of consistent, immediate collaboration between:

- Child Safety
- Police
- Health services
- Education providers

This results in:

- Fragmented information sharing
- Delayed decision-making
- Reduced effectiveness in safeguarding responses

8. Comparative Practice Insight (United Kingdom)

In the UK, safeguarding systems include:

- **24-hour response expectations** for high-risk cases
- Multi-agency safeguarding approaches
- Statutory child protection intervention where risk is identified
- Formal child protection plans with regular multi-agency review

These mechanisms support:

- Earlier identification and management of risk
- Clear accountability across agencies
- Reduced reliance on crisis-driven removal

9. Case Example (Anonymised)

A practitioner was involved with a 13-year-old child initially referred for school non-attendance.

Further information identified a history of repeated missing episodes, with the child going missing on multiple occasions for periods ranging from several days to several weeks.

During these episodes:

- The child was known to be sleeping rough in high-risk environments
- There was exposure to individuals involved in substance misuse and violence
- On return home, the child frequently presented with unexplained injuries, including bruising and cuts

- The child appeared withdrawn and reluctant to discuss their experiences

The child was also observed to return with new clothing, shoes, and money without a clear explanation, raising concerns about possible exploitation.

A referral was made to child protection services outlining concerns of significant harm. However:

- There was no timely response or assessment
- The case was not progressed due to the parents being considered “willing and able”

Despite this, the parents reported being unable to manage the situation and feeling unsupported.

Over time, the child’s behaviour escalated to include:

- Theft and burglary
- Substance-related activity
- Risk to other children, including drug-related behaviour within a school setting

It was later identified that an address the child frequently attended was associated with adults facilitating access to substances.

Intervention remained limited to early intervention services, which did not have the statutory authority or resources to manage the level of risk.

When the child changed schools, support ceased due to service limitations, leaving the family without ongoing assistance.

This example highlights gaps in:

- Response to repeated missing episodes
- Recognition and disruption of potential exploitation
- Thresholds for statutory intervention
- Multi-agency information sharing and coordination
- Continuity of support

10. Impact on Children and Communities

These systemic gaps contribute to:

- Children remaining in situations of abuse or neglect
- Adolescents engaging in escalating risk-taking behaviour

- Increased likelihood of:
    - Youth justice involvement
    - Harm to other children
    - Ongoing cycles of victimisation and offending

11. Recommendations

It is recommended that Queensland consider:

11.1 Mandatory 24-Hour Response for High-Risk Notifications

- Initial action and multi-agency information sharing within 24 hours

11.2 Introduction of a Structured Statutory Child Protection Stage

- Formal intervention when risk of significant harm is identified
- Clear expectations, monitoring, and accountability

11.3 Implementation of Formal Child Protection Plans

- Multi-agency plans outlining risks, actions, and responsibilities
- Regular review and oversight

11.4 Strengthened Multi-Agency Coordination

- Early involvement of police, health, and education
- Defined roles and responsibilities

11.5 Enhanced Response to Adolescents and Missing Children

- Clear protocols for high-risk behaviours and missing episodes
- Multi-agency responses
- Increased support for parents

11.6 Oversight and Accountability

- Monitoring of response times and intervention outcomes
- Transparent reporting

12. Conclusion

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There is an opportunity to strengthen Queensland's child protection system by introducing earlier, structured, and coordinated intervention.

This would improve safety for children, support families more effectively, and reduce escalation into crisis and youth justice involvement.